ALLIANCE FOR PHYSICAL THERAPY QUALITY AND INNOVATION

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Via Electronic Submission

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1784-P
7500 Security Boulevard
Baltimore, MD 21244

Re: CMS-1784-P, Medicare and Medicaid Programs: CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program: Proposed Rule, Fed. Reg. Vol. 88, No. 150, (August 7, 2023).

Dear Administrator Brooks-LaSure:

This letter represents the collective comments of the Alliance for Physical Therapy Quality and Innovation (the "APTQI") to the Centers for Medicare and Medicaid Services (CMS) regarding the above referenced "Proposed Rule to Payment Policies Under the Physician Fee Schedule et al." for calendar year 2024, published in the Federal Register on August 7th, 2023 ("Proposed Rule").

By way of introduction, we are among the nation's leading providers of outpatient rehabilitation care, and collectively employ or represent over 25,000 physical and occupational therapists and furnish physical and occupational therapy services on an annual basis to Medicare beneficiaries throughout the United States. APTQI membership consists of affiliate and board member entities of varying size and geographic scope, which in aggregate provide patient care services in over 6,000 outpatient rehabilitation clinical sites.

I. Preliminary Statement

We appreciate the opportunity to comment on the Proposed Rule. Many of the areas where CMS seeks feedback regarding Medicare Outpatient Part B therapy services are important to the APTQI's core mission: "*Ensuring patient access to value driven physical therapy care.*" We support CMS' commitment to enhance its partnerships with a delivery system in which providers

are supported in achieving better patient outcomes at a lower cost for Medicare beneficiaries. APTQI shares the core belief that any proposals related to physical therapy services should (a) drive payment in line with the value physical therapy services deliver to the patient and other providers in the continuum of care; (b) reduce unnecessary regulatory and administrative burdens unrelated to improving the quality of patient care; and (c) be transparent to patients and all stakeholders.

II. APTQI Proposes Delaying the Implementation of the G2211 Code.

The Proposed Rule would impose yet another round of significant reductions for physical and occupational therapy services for 2024. As demonstrated in the proposed rule, physical and occupational therapy providers would see a combined impact of negative 3.6%.

APTQI recognizes that CMS must implement any changes with budget neutrality. Because of this, the timing and magnitude of any changes must be carefully considered. Implementing the G2211 code at a time when the fee schedule has not kept up with inflation creates large negative changes in reimbursement. When combined, the previously implemented and future proposed reductions would total almost 10% from 2020 to 2024 for therapy services.

This proposed cut is the latest in a history of cuts to physical therapy services over the past decade. If implemented, the proposed 2023 reduction would come after numerous therapy-specific reductions. These include a multiple procedure payment reduction (MPPR) in 2011 which was further deepened in 2013, and reductions to two of the most common procedural codes used by physical therapists, Therapeutic Exercise (97110) and Manual Therapy (97140), which were instituted in 2018 after they went through the misvalued code initiative. In addition, the 15% reduction applied to services provided by therapist assistants mandated by Congress took effect in 2022.

Implementation of the redistribution will also have a negative impact on opioid misuse and falls. If CMS wants to reach the stated goal of decreasing opioid use, access to physical therapy should be expanded– not cut. In its Guideline for Prescribing Opioids for Chronic Pain, the Centers for Disease Control and Prevention (CDC) recommends physical therapy as an alternative to opioids for the treatment of chronic pain. The CDC notes physical therapy is especially effective at reducing pain and improving function in cases of low back pain, fibromyalgia, and hip and knee osteoarthritis. Providing this type of nonpharmacological therapy is only possible if we are able to keep our doors open and continue seeing Medicare patients. This is even more crucial as 30% of patients suffering from chronic low back pain are taking opioids despite medical guidelines cautioning against their use for this condition.[1]

Moving forward, it is imperative that CMS acknowledge the important role physical therapists play in the prevention and treatment of acute and chronic pain. The solution requires more than limiting access to drugs. Rather, Medicare payment policies should incentivize collaboration, assessment, and care coordination with foundational care team partners, particularly physical

[1] https://www.painnewsnetwork.org/stories/2022/8/11/over-72-million-americans-suffer-chronic-low-back-pain, Accessed September 6, 2023.

therapists. CMS and Congressional policies to reduce reimbursement for physical therapy services is misguided (i.e., through MPPR, misvalued codes, PTA/OTA reductions, PT/OT value redistributions, etc.) at a time when benefit design and reimbursement models should support early access to nonpharmacological interventions -- including physical therapy for the primary care of pain conditions. The continuing payment reduction policies for physical therapy services impose greater challenges on physical therapy clinics to keep their doors open, thus placing at risk Medicare beneficiary access to nonpharmacological treatments for pain. It is critical that CMS, in conjunction with other state and federal agencies, examine how to reduce barriers to nonpharmacological treatment options such as physical therapy that serve as an alternative to opioids. If CMS, policymakers, and other stakeholders remain silent on the benefit of nonpharmacological treatments, this will only reinforce the idea that pharmaceuticals are the only option—an option with significant risk of harm.

The availability of physical therapy should be encouraged among older Americans because of the critical role it plays in preventing harmful senior falls. Accounting for roughly 300,000 hip fractures, 800,000 hospitalizations, and 27,000 deaths every year, falls are the leading cause of injury-related emergency room visits for older Americans.[2] It is estimated that the cost to treating injuries due to falls will increase to $101 billion by 2030, underscoring the need to support fall prevention strategies and treatments.[3] With fall deaths increasing every year, undermining beneficiary access to fall prevention treatments offered by physical therapy is both short sighted and financially ill-advised. As aforementioned, the costs that falls incur on America's healthcare system are exorbitant and unsustainable. Siphoning resources away from physical therapy services as the fall epidemic increases in size and scope will only result in more injury-related costs further down the line. Diminishing access to physical therapy services that save lives and reduce downstream medical costs is counterproductive, plain and simple. APTQI urges CMS to alter their recently Proposed Rule to ensure beneficiary access to physical therapy is preserved well into the future.

To underscore the relationship between physical therapy services and falls and opioid use, APTQI commissioned HMA to study how physical therapy may benefit Medicare patients who suffer from fall-related injuries. They analyzed patients who suffered fall-related injuries and compared those who did and did not receive physical therapy in the post-fall period. The analysis showed that the Medicare patients who used physical therapy were 50% less likely to visit the emergency room (ER) or be hospitalized for a follow-up injury in the 6 months following their initial fall. The relative odds of ER and hospitalization were lowest for patients who had over 30 sessions of physical therapy. Those who used physical therapy were also 39% less likely to use opioids in the 6 months following their initial fall.

Considering the potential disastrous effects of the redistribution proposed in this rule for 2024, we urge CMS to postpone implementing G2211 until after 2025 when the fee schedule is eligible for inflation adjustments once again.

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[2] https://www.ncoa.org/article/get-the-facts-on-falls-prevention, Accessed September 6, 2023.
[3] https://pubmed.ncbi.nlm.nih.gov/29512120/ , Accessed September 6, 2023.

II. APTQI Agrees with Proposal to Establish a General Supervision Policy for Therapist Assistants Providing Remote Therapeutic Monitoring (RTM) Services.

APTQI agrees that CMS should pursue all avenues to increase beneficiary access to RTM services. APTQI appreciates that CMS recognizes the fact that current supervision requirements in the private practice setting makes it almost impossible to utilize physical therapist assistants (PTAs) or occupational therapist assistants (OTAs) for RTM services. Allowing PTAs and OTAs to operate under general supervision in private practice settings provides a safe way for patients to receive RTM services. **APTQI urges CMS to finalize their proposal to establish a general supervision policy for therapist assistants working in private practice settings and providing RTM services.**

III. APTQI Urges CMS to Allow PTAs and OTAs to Practice at the Top of their License and Practice under General Supervision in Private Practice Settings.

APTQI appreciates CMS' decision to consider revising the direct supervision policy for private practice clinics of their PTAs and OTAs. Currently, direct supervision of PTAs by PTs and OTAs by OTs is required in the private practice setting for Medicare patients. Under direct supervision, the PT or OT is required to be physically present and immediately available for direction and supervision of the PTA or OTA. The PT or OT will have direct contact with the patient/client during each visit, as well as all encounters with a patient/client in a 24-hour period. In contrast, only general supervision of PTAs or OTAs is required by PTs and OTs in other outpatient provider settings (i.e., hospitals, SNFs, rehabilitation facilities, etc.). Under general supervision, the PT or OT is not required to be on site but must be available by audio telecommunications.

We urge CMS to standardize the supervision requirement under Medicare across all settings which will bring Medicare policy in line with the vast majority of state-level requirements. Currently, only New York and the District of Columbia require direct supervision of PTAs by PTs and only one state, Kentucky, requires direct supervision of OTAs by OTs. Furthermore, making the supervision requirement consistent across outpatient settings will decrease administrative burden and confusion as well as ease compliance on the part of providers who work and manage staff in more than one type of outpatient setting.

APTQI members have not encountered any patient safety issues with having PTAs and OTAs operate under general supervision in rehab agencies. PHE-related waivers permitted direct supervision via audio-visual telecommunications and services were provided safely and effectively. As to the issue of requiring periodic visits or limiting types of services provided, APTQI believes those questions should be left to the respective state boards. Provision of services becomes much more burdensome and confusing when Medicare requirements differ from the state. The state board issues the license and CMS should defer to the provisions of the state practice act on such issues.

Changing the supervision requirement to general would have the added benefit of improving access to care. With the direct supervision requirement, the therapist must be physically present

when the therapist assistant delivers care. This restricts clinic operating hours, especially in rural areas where clinics are typically understaffed. General supervision would allow the clinic to extend their operating hours by virtue of allowing the therapist assistant to provide care before or after a therapist's shift has ended. **Therefore, APTQI Urges CMS to Allow PTAs and OTAs to Practice at the Top of their License and Practice under General Supervision in Private Practice Settings.**

IV. APTQI Supports the Re-Review of the Clinical Labor Time Entries for the 19 Therapy Codes Identified in the Proposed Rule

Therapy providers have long held that the American Medical Association's (AMA's) Relative Value Scale Update Committee (RUC) and Healthcare Professional Advisory Committee (HCPAC) had incorrectly applied Multiple Procedure Payment Reductions (MPPR) to the 19 always therapy codes. This has resulted in therapists' receiving underpayment for therapy services since 2018. CMS must implement any upward revisions to the clinical labor time entries of the therapy codes as quickly as possible after the AMA RUC HCPAC has completed their work.

V. APTQI Proposes a Change to Allow for a Plan of Care to be Presumed Certified Providing Certain Conditions are Met.

APTQI appreciates that CMS is constantly searching for ways to decrease administrative burden on providers and to put patients over paperwork. One way in which this can be achieved is to change the plan of care certification requirements for outpatient therapy services. APTQI recognizes that CMS requires that therapy services must be required because the patient needed therapy services (42 CFR 424.24(c), MBPM §220.1.3), provided under a plan of care established by a physician/NPP or a therapist (42 CFR 424.24(c), MBPM §220.1.2), and furnished while the patient is or was under the care of a physician (42 CFR 424.24(c), MBPM §220.1.1). However, the regulations state that in order to meet these three conditions, they must have the physician/NPP certify the plan of care after it has been created.

Across the over 6,000 locations operated by APTQI members, thousands of Medicare beneficiaries seek therapy services every day. **Over 95% of these patients arrive for their first visit with a referral from a physician/NPP in hand and the therapist creates a plan of care**. The signed referral is proof that the patient is under the care of a physician/NPP and that therapy services are needed, however the therapist must send the plan of care back to the referring physician to get another signature on the same patient for the same diagnosis in order to meet the requirement for coverage and payment. APTQI recognizes the importance of regulatory requirements to ensure medically necessary services. However, in most cases, the physician has already indicated the need for medical necessary services by ordering therapy services. In fact, the MPBM states there is no Medicare requirement for an order, however, "when documented in the medical record, an order provides evidence that the patient needs therapy services and is under the care of a physician."

The process of sending, tracking, and ensuring physician/NPP signature on a plan of care for a patient who is in possession of a referral is burdensome, not only for the therapist, but also for the physician who has already written the referral and is now asked to duplicate their work by

certifying a plan of care for the same patient and diagnosis. The time spent by providers and clinicians in faxing (and in some cases refaxing) documents, calling physician offices to follow up, documenting attempts at certification in tracking logs, and in some cases even visiting physician offices in person to gain certification is time taken away from patient care. **In order to alleviate providers from this burden, APTQI urges CMS to allow for a certified plan of care to be presumed certified if the therapist has received a referral from a physician or NPP that is dated no more than 90 days prior to the initiation of therapy services, and documented evidence that the plan of care has been delivered to the physician.** With this change, therapists still have to communicate with the physician that therapy services have been initiated, but it gives physicians the option to communicate any instructions back to the therapist or let their original referral stand.

Under this change, if a patient did not present with a referral, or the initial duration of the first plan of care needed to be exceeded, APTQI supports the need for a certified plan of care to ensure requirements are being met.

VI. Conclusion

APTQI is in favor of value driven care and reimbursement. We ask that CMS revisit the proposed reductions for physical/occupational therapy and fully consider the impact of those cuts on two of the most important health issues of our day, opioid misuse and falls resulting in injury and hospitalization. Considering the enormity of these cuts, it is clear that physical therapy for Medicare patients is at serious risk. If CMS proceeds with the 2024 and subsequent cuts as proposed, the country will undoubtedly see practice closures and providers opting out of the Medicare program, which would then stifle access to important therapy treatments.

APTQI appreciates the opportunity to provide comments to CMS on the Proposed Rule for CY 2024. We encourage CMS to continue to work with professional societies such as APTQI through the rulemaking process. APTQI looks forward to continued dialogue with CMS officials about these and other issues affecting therapy services. If you have any questions, or would be interested in further collaboration, please feel free to contact Nikesh “Nick” Patel, PT, DPT Executive Director, at 713-824-6177 or npatel@aptqi.com.

Very truly yours,

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By: _____
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